SAMPLE
Dental Claim
For Training Purpose

American Dental Association Dental Claim Form

HEADER INFORMATION

1. Type of Transaction (Mark all applicable boxes)
☒ Statement of Actual Services ☐ Request for Predetermination/Preauthorization
☐ EPSDT/Title XIX

2. Predetermination/Preauthorization Number
9156446001

INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION

3. Company/Plan Name, Address, City, State, Zip Code
Montana Medicaid/ACS
PO Box 8000
Helena MT 59604

OTHER COVERAGE

4. Other Dental or Medical Coverage? ☐ No (Skip 5-11) ☒ Yes (Complete 5-11)

5. Name of Policyholder/Subscriber in #4 (Last, First, Middle Initial, Suffix)
Paul Plaque

6. Date of Birth (MM/DD/CCYY)	7. Gender	8. Policyholder/Subscriber ID (SSN or ID#)
3/26/1979	☒M ☐F	666 55 4444

9. Plan/Group Number	10. Patient's Relationship to Person Named in #5
123456	☐ Self ☐ Spouse ☒ Dependent ☐ Other

11. Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code
BCBS of MT
27 Cuspid Court
Helena MT 59601

POLICYHOLDER/SUBSCRIBER INFORMATION (For Insurance Company Named in #3)

12. Policyholder/Subscriber Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code
Patty Plaque
18 Molar Drive
Wisdom MT 59632

13. Date of Birth (MM/DD/CCYY)	14. Gender	15. Policyholder/Subscriber ID (SSN or ID#)
11/10/1993	☐M ☒F	999 88 7777

16. Plan/Group Number	17. Employer Name
	Medicaid

PATIENT INFORMATION

18. Relationship to Policyholder/Subscriber in #12 Above	19. Student Status
☒ Self ☐ Spouse ☐ Dependent Child ☐ Other	☒ FTS ☐ PTS

20. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code
Patty Plaque
1234 Molar Drive
Wisdom MT 59632

21. Date of Birth (MM/DD/CCYY)	22. Gender	23. Patient ID/Account # (Assigned by Dentist)
11/10/1993	☐M ☒F	999 88 7777

RECORD OF SERVICES PROVIDED

	24. Procedure Date (MM/DD/CCYY)	25. Area of Oral Cavity	26. Tooth System	27. Tooth Number(s) or Letter(s)	28. Tooth Surface	29. Procedure Code	30. Description	31. Fee
1	9/1/2009					D0120	Oral Evaluation	28.00
2	9/1/2009					D0220	Intraoral Periapical film	24.00
3	9/1/2009					D0230	Intraoral Periapical addtional film, 4 units	40.00
4	9/1/2009					D1206	Flouride Varnish	24.00
5	9/1/2009			18		D1351	Sealant	32.00
6	9/1/2009			31		D1351	Sealant	32.00
7	9/1/2009			UL		D4210	Gingivectomy	350.00
8	9/1/2009			3		D2750	Crown Porcelain, w/high noble metal	991.00
9								
10								

MISSING TEETH INFORMATION

34. (Place an 'X' on each missing tooth)

Permanent																Primary										32. Other Fee(s)	
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	A	B	C	D	E	F	G	H	I	J		
32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17	T	S	R	Q	P	O	N	M	L	K	33. Total Fee	1521.00

35. Remarks Co-pay exempt, patient is pregnant. EOB attached from BCBS of MT.

AUTHORIZATIONS

36. I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law, or the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with this claim.

X signature on file 9/1/2009
Patient/Guardian signature Date

37. I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the below named dentist or dental entity.

X
Subscriber signature Date

ANCILLARY CLAIM/TREATMENT INFORMATION

38. Place of Treatment ☒ Provider's Office ☐ Hospital ☐ ECF ☐ Other

39. Number of Enclosures (00 to 99) Radiograph(s) Oral Image(s) Model(s)

40. Is Treatment for Orthodontics? ☒ No (Skip 41-42) ☐ Yes (Complete 41-42)

41. Date Appliance Placed (MM/DD/CCYY)

42. Months of Treatment Remaining

43. Replacement of Prosthesis? ☐ No ☐ Yes (Complete 44)

44. Date Prior Placement (MM/DD/CCYY)

45. Treatment Resulting from ☐ Occupational illness/injury ☐ Auto accident ☐ Other accident

46. Date of Accident (MM/DD/CCYY)

47. Auto Accident State

BILLING DENTIST OR DENTAL ENTITY (Leave blank if dentist or dental entity is not submitting claim on behalf of the patient or insured/subscriber)

48. Name, Address, City, State, Zip Code
Crown Clinic
89 Base Metal Drive
Big Drill MT 59625

49. NPI	50. License Number	51. SSN or TIN
1234567891		

52. Phone Number (406) 555 - 5555 52A. Additional Provider ID ZZ1223G0001X

TREATING DENTIST AND TREATMENT LOCATION INFORMATION

53. I hereby certify that the procedures as indicated by date are in progress (lor procedures that require multiple visits) or have been completed.

X Dennis Canine, DDS 9/2/2009
Signed (Treating Dentist) Date

54. NPI	55. License Number
1110563265	

56. Address, City, State, Zip Code	56A. Provider Specialty Code
16 Crossbite Lane Bridge MT 59628	1223P0221X

57. Phone Number (406) 555 - 5555 58. Additional Provider ID

J400 (Same as ADA Dental Claim Form – J401, J402, J403, J404)

DENTAL CLAIMS (last update 03/2011)

Frequent Denial Reasons or other problem areas:

1. **Recipient is not eligible for that date of service.** Check eligibility monthly using the web portal, FAX back, Automated Voice Response (AVS), or call ACS Provider Relations. *NEW,* Suspended Spans for inmates in a public institution.
2. **Exact Duplicate**. The claim was already submitted and paid.
3. **The Prior Authorization (PA) number is missing or invalid**. Enter the PA number in field #2 on the claim form. DO NOT attach the PA notice or write it in the remarks field.
4. **There is another insurance company, Third Party Liability (TPL)**. Bill the other company first, if you already have, then include the Explanation of Benefits (EOB) with the claim form.
5. If the client is **co-pay** exempt, under 21, pregnant, in an institution (inpatient hospital, skilled nursing facility, intermediate care facility) or an emergency. Write co-pay exempt in field 35.
6. The **date the treating dentist signs** field 53 **must be on or after the date of service**.
7. If a procedure code is utilizing **multiple units**, enter them on one line and in the description field after the procedure description list the number of units used. In the fee field multiply your usual and customary (U & C) fee times the number of units. Not for electronic claims.
8. Be aware of **limits** per tooth, per denture, per time frame, per age, etc.
9. Be aware of which procedures require **prior authorization** (crowns and ortho).
10. Work your denials weekly! You most likely will just need to resubmit once the correction is made. Once a claim is **paid incorrectly** you can then file an adjustment.
11. Even if you have a PA for ortho or crowns, or essential for employment, they MUST also have current eligibility at the time of service for the claim to be paid.
12. If the patient is BASIC Medicaid, Dental services are only available if the **Essential for Employment** forms (pages 1 and 2) are attached or the **Emergency Dental** form is attached.

OTHER:

DO NOT Send x-rays for crown prior authorization requests; describe the medical need in words in box #35.

Dental Program Officer: Jan Paulsen 406-444-3182 or jpaulsen@mt.gov